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Board of Registration of Podiatry
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VERIFICATION REQUEST

Massachusetts' Licensee: Please provide the information requested below to process your verification request. Additionally, please forward this request **along with** a check or money order for $15.00 payable to: the Commonwealth of Massachusetts.

To Be Completed By Licensee (Please Print In Ink)

I, the undersigned Licensee, was granted a license to practice _____
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Massachusetts. I request that the Board of Registration of Podiatry forward verification of my licensure to the recipient stated below:

Name:_____

Street:_____

City:_____ State _____

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Furthermore, I hereby **authorize** the Board of Registration of Podiatry to release my information, **favorable or otherwise**, directly to the above stated recipient.

*Licensee's signature **& Date*** _____

*Licensee's printed or typed name*_____

*Licensee's Address:*_____

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